MONTANA
Department of Public Health & Human Services

ANNUAL SURVEY OF AMBULATORY SURGICAL FACILITIES 2005

PLEASE RETURN THIS SURVEY NO LATER THAN JANUARY 31, 2006.

Mail or fax a typed or clearly printed copy to: Department of Public Health & Human Services, Certificate of Need Program, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953, Fax 444-1742.

Name and Address of Facility:

E-Mail Contact:

Please refer to the instructions on pages 5 and 6 of this survey.

A. REPORTING PERIOD

Required reporting period is January 1, 2005, through December 31, 2005.

1. Was the facility in operation 12 full months at the end of the period? ☐ Yes ☐ No

   If NO, please report the number of days in operation. _____

B. CLASSIFICATION

1. ☐ NOT FOR PROFIT ☐ FOR PROFIT
2. a. Please name owner of facility (company, corporation)

   b. Please name management firm of facility (N/A if management is not provided through contract)

3. a. Is the facility operated as part of a chain, whether for profit or not?
   ☐ Yes ☐ No

   b. If YES, please give the name and address of the PARENT organization.

C. UTILIZATION OF SUITES AND SERVICES

1. TOTAL NUMBER OF PROCEDURES PERFORMED (Excluding exploratory/diagnostic endoscopies) _____

2. TOTAL NUMBER OF EXPLORATORY/ DIAGNOSTIC ENDOSCOPIES PERFORMED _____

3. TOTAL NUMBER OF SURGERY SUITES_____

4. TOTAL NUMBER OF PATIENTS _____

   (Patient should be counted only once for multiple procedures performed during same day visit)

5. TOTAL NUMBER OF PATIENTS TRANSFERRED TO ACUTE CARE HOSPITAL DURING SURVEY PERIOD _____

6. TYPE OF SURGERY PERFORMED (List 12 most frequently performed)

	SURGERY TYPE	CPT CODE NUMBER	NUMBER OF PROCEDURES PERFORMED		SURGERY TYPE	CPT CODE NUMBER	NUMBER OF PROCEDURES PERFORMED
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			
6.				12.			

D. PERSONNEL DATA

	FULL TIME (35 HRS/WK)	**PART TIME (<35 HRS/WK)**
1. NURSING (RN/LPN)	_____	_____
2. AIDES/TECHNOLOGISTS	_____	_____
3. ADMINISTRATION	_____	_____
4. OTHER	_____	_____
5. TOTAL EMPLOYEES (All Categories)	_____	_____

E. FINANCIAL DATA. If actual figures are not available, please estimate (indicate which figures have estimated). Round to the nearest dollar.

1. Total annual operating expenses from most recent financial statement:
   a. Total gross revenue $_____
   b. Payroll expenses $_____
   c. Non-payroll expenses $_____
   d. Total expenses $_____

   Compare financial data with 2004 Annual Survey financial data and explain any differences exceeding 10%.

2. Fiscal year ending date ___/___/____

3. Facility's average cost and average charge from most recent financial statement:

AVERAGE COST	AVERAGE CHARGE
a.	b.

   c. If available, please also submit a copy of the facility's posted charges and costs for each procedure type performed.

4. Procedures and revenue breakdown by payor source:

PAYOR SOURCE	NUMBER OF PROCEDURES	PERCENT OF OPERATING REVENUE
MEDICARE		
MEDICAID		
INSURANCE		
PRIVATE PAY		
UNFUNDED		
OTHERS		
TOTAL		

F. PATIENT ORIGIN DATA.

COUNTY	TOTAL	COUNTY	TOTAL	COUNTY	TOTAL
Beaverhead		Hill		Ravalli	
Big Horn		Jefferson		Richland	
Blaine		Judith Basin		Roosevelt	
Broadwater		Lake		Rosebud	
Carbon		Lewis & Clark		Sanders	
Carter		Liberty		Sheridan	
Cascade		Lincoln		Silver Bow	
Chouteau		Madison		Stillwater	
Custer		McCone		Sweet Grass	
Daniels		Meagher		Teton	
Dawson		Mineral		Toole	
Deer Lodge		Missoula		Treasure	
Fallon		Musselshell		Valley	
Fergus		Park		Wheatland	
Flathead		Petroleum		Wibaux	
Gallatin		Phillips		Yellowstone	
Garfield		Pondera		Unknown/In-State	
Glacier		Powder River		Out-of-State	
Golden Valley		Powell			
Granite		Prairie		TOTAL **(Must Equal C.4.)**	

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DATE SURVEY COMPLETED ___/___/____

ADMINISTRATOR'S NAME (type or print) _____

ADMINISTRATOR'S SIGNATURE _____

If we have questions about any of the responses on this survey, whom should we contact?

NAME _____ **TELEPHONE** _____

If you have any questions, please contact the Certificate of Need Program, Department of Public Health & Human Services, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953. Telephone (406) 444-9519, Fax (406) 444-1742 or E-mail psourbeer@mt.gov

Thank you!

INSTRUCTIONS FOR AMBULATORY SURGICAL FACILITIES 2005

Address: Please write the name and address of the facility on Page 1 of the survey.

Copies: Mail a typed or clearly printed copy to: Department of Public Health & Human Services, Certificate of Need Program, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953. **Keep a copy of the survey for your files**.

Note: Answer every item. Enter "O" to mean none.

B. CLASSIFICATION

1. The following definitions apply to this section of the survey:

Not For Profit:	Excess revenue retained by the corporation; exempt from federal income taxation under section 501 of the Internal Revenue Code of 1954.
For Profit (Proprietary):	Excess revenue distributed to owners or shareholders or held as retained earnings, subject to federal taxation.

2. Please indicate the governmental entity (state, city, county or federal), corporation, company, etc., responsible for the ownership and management of the agency.

C. UTILIZATION OF SUITES AND SERVICES. Report utilization for a full 12-month period.

3. "Total number of surgical suites" should include the number of suites licensed and certified on the last day of the reporting period. A laser or procedure room not meeting physical plant requirements as an ambulatory surgical center suite should not be included.

D. PERSONNEL DATA. Exclude volunteers and all personnel whose salary is financed entirely by outside research grants.

For combined facilities, report **only** the personnel for the ambulatory surgical facility.

E. **FINANCIAL DATA**. Report expenses for the full 12-month period. If actual figures are not available, please estimate (indicate which figures have been estimated). Please do not use "N/A" in this section. Round all figures to the nearest dollar.

1. a. Total gross revenue: Includes total revenues from direct patient care and all other sources.

   b. Payroll expenses: Report salaries for full-time and part-time personnel as reported in Section D, Personnel Data.

   c. Non-payroll expenses: Include all costs for goods and services that have been used or consumed during the reporting period.

   Compare financial data with 2004 Annual Survey financial data and explain any differences exceeding 10%.

F. **PATIENT ORIGIN DATA**. Report all patients served by the facility for the reporting year by county of origin. **(Total reported in patient origin must equal C.4.).**

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